TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Courtney Eckelkamp, D.C.

Respondent Name
Metropolitan Transit Authority Harris County

MFDR Tracking Number
M4-17-0989-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
December 7, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "DESIGNATED DR REFERRED TESTING NO PAYMENT RECEIVED"

Amount in Dispute: $851.16

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "There has been no documentation submitted that supports submaximal cardiovascular endurance tests which measure aerobic capacity using stationary bicycle or treadmill. As such, the respondent maintains its position that CPT code 97750-FC was correctly denied in accordance with the TDI-DWC rule 134.204(g)."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 29, 2016	Functional Capacity Evaluation, 16 units	$851.16	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204 sets out the fee guidelines for division-specific services from March 1, 2008 until September 1, 2016.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 150 – Payment adjusted because the payer deems the information submitted does not support this level of service.

- Comments: 150 – Documentation submitted does not support the level of services required for an FCE. Per DWC rule 134.204 (g): FCE's shall also include the following elements:
  (3). Functional abilities tests, which include the following:
  (C) Submaximal cardiovascular endurance tests which measure aerobic capacity using stationary bicycle or treadmill;
- W3 – Additional reimbursement made on reconsideration.
- 193 – Original payment decision is being maintained. This claim was processed properly the first time.
- Comments: Per rule 134.804, W3 is to be used when a payment is made following a request for reconsideration. The service adjustment amount associated with this code may be zero. Original payment is being maintained.

Issues

Are Metropolitan Transit Authority Harris County's reasons for denial of payment supported?

Findings

Courtney Eckelkamp, D.C. is seeking reimbursement for a functional capacity evaluation using procedure code 97750-FC. Metropolitan Transit Authority Harris County (MTAHC) denied disputed services with claim adjustment reason code 150 – "Payment adjusted because the payer deems the information submitted does not support this level of service."

28 Texas Administrative Code §134.204(g) defines the elements required for a functional capacity evaluation and is considered a division-specific service when billed with procedure code 97750 and modifier "FC." The required elements for this type of evaluation include 28 Texas Administrative Code §134.204(g)(3)(C) "submaximal cardiovascular endurance tests which measure aerobic capacity using stationary bicycle or treadmill."

Review of the documentation submitted by Dr. Eckelkamp does not include submaximal cardiovascular endurance tests which measure aerobic capacity using stationary bicycle or treadmill. The insurance carrier's denial reason is supported. Additional reimbursement cannot be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

	Laurie Garnes	December 30, 2016
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.